VIRGINIA STATE-30 J-1 VISA WAIVER PROGRAM
VERIFICATION OF EMPLOYMENT

Reporting period from _____to _____

(Please report for the full amount of time at the sponsoring facility)

PHYSICIAN: _____

First Name *Middle Name* *Last Name*

_____

Street *City* *State* *Zip*

Social Security # _____ J-1 Visa Waiver #_____Passport #_____

Home Phone Number: _____ Email Address: _____

INS Approval Date or Actual Employment Start Date, whichever is later. _____

(If more than one medial practice address, please attach separate sheet)

1. I maintain a full-time clinical practice at:

   Name of Medical Practice: _____

   Street Address: _____

   City/State/Zip: _____

   Telephone Number: _____

   HPSA (include specific county/city, census tract, district, etc.): _____

2. During the reporting period, I maintained office hours (use "X" for days not usually practicing). DO NOT include "on-call" status time.

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
From:							
To:							

3. During the reporting period, approximately _____hours/week were required to treat hospitalized patients of the practice at _____ Hospital.

4. During the reporting period, I was absent from the practice for_____days due to illness, vacation, or for continuing professional education.

5. For this reporting period:

   a. Number of office visits (do not include telephone consultations or hospital visits) _____
   b. Number of visits from 5a who reside in a Health Professional Shortage Area (HPSA) _____
   c. Number of hospital visits _____
   d. Number of patient visits for whom a Medicare claim was submitted _____
   e. Number of patient visits for whom a Medicaid claim was submitted _____
   f. Number of patients wherein services were rendered at a rate less than usual customary fee _____
   g. Number of patient visits for which no charge was made (based on inability to pay) _____

6. My Medicare Provider Number is: _____

7. My Medicaid Provider Number is: _____

CERTIFICATION

I CERTIFY THAT THE ABOVE REPORTED INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND ACCURATELY REFLECTS ACTIVITIES TO THE FULFILLMENT OF MY OBLIGATION TO THE VIRGINIA J-1 VISA WAIVER PRGORAM.

_____ _____

Physician's Name: (Print or Type) Date

_____

Physician's Signature

ENDORSEMENT

I HAVE REVIEWED THE ABOVE REPORT BEING SUBMITTED BY_____WHO BEGAN HIS/HER PRACTICE WITH US ON _____. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IS ACCURATE AND CORRECT.

Organization: _____ Date: _____

Signature: _____ Title: _____